conditions. Isolated anti-DFS70 could be used as a differential marker for AARD.

Objectives: To analyse the clinical significance of isolated anti-DFS70 antibodies.

Methods: All the serum samples obtained in our hospital between January 2017 to December 2018 that were positive for ANA testing and negative for anti-extractable nuclear antigen (ENA) antibodies panel, were tested for anti-DFS70 (HEp-2/DFS70 knock-out IFA, A.MENARINI diagnostics). Demographic and clinical data were collected from anti-DFS70 positive adult patients.

Results: From 145 samples tested 68 were found positive for monospecific anti-DFS70: 82.4% were women and the median age was 55.4±14.4 years. The ANA titer was greater than 1/320 in all of cases and 26.5% of patients had two positive determinations DFS70 separated 15.4±9.2 months. The reasons for requesting ANA were diverse (arthralgias in 33.8% of the cases), and most of them were ordered from primary care. Clinical follow-up was performed in 66.1% of the patients for a mean of 2.9 years (between 2 months and 7 years). Only 3 patients (4.1%) had a defined AARD: 2 systemic lupus erythematosus and 1 antiphospholipid syndrome, diagnosed years before. There were 5 patients with rheumatoid arthritis (7.3%) and one had sarcoidosis. Nineteen patients (27.9%) had an organ-specific autoimmune disease: 14 autoimmune hypothyroidism, 2 autoimmune hepatitis, 2 primary biliary cholangitis and 1 immune thrombocytopenia. Six patients (8.8%) were followed up because of undifferentiated connective tissue disease (they did not meet criteria for AARD). Other clinical associations found were obesity (13.2%), depression (8.8%), sleep disorders (8.8%), fibromyalgia 5.8%, cancer, asthma and psoriasis (2.9% each one of them). Thirty-nine patients (57.3%) did not have any autoimmune disease (systemic or localized).

Conclusion: In our experience, patients with monospecific anti-DFS70 ANA rarely present AARD, even though 42.7% of subjects showed autoimmune features. Rheumatoid arthritis patients occasionally had an isolated anti-DFS70 ANA. Therefore isolated anti-DFS70 may be potentially considered as marker of benign autoimmunity.

REFERENCES

- [1] Michael Mahler, Luis E. Andrade, Carlos A. Casiano, Kishore Malyavantham & Marvin J. Fritzler (2019): Anti-DFS70 antibodies: an update on our current understanding and their clinical usefulness, Expert Review of Clinical Immunology, DOI: 10.1080/17446666X.2019.1562903.
- [2] Bonroy C, Schouwers S, Berth M, Stubbe M, Piette Y, Hoffman I, et al.: The importance of detecting anti-DFS70 in routine clinical practice: comparison of different care settings. Clin Chem Lab Med 2018; 56:1090-9.
- [3] Shovman O, Gilburd B, Chayat C, Amital H, Langevitz P, Watad A, et al.: Prevalence of anti-DFS70 antibodies in patients with and without systemic autoimmune rheumatic diseases. Clin Exp Rheumatol 2017; 36:121-6.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.6286

AB1155

CORRELATION BETWEEN NAILFOLD VIDEOCAPILLAROSCOPY PATTERNS, LEFT VENTRICLE DYSFUNCTION AND PULMONARY DISEASE IN SYSTEMIC SCLEROSIS

Monaco Lucio¹, Francesco Masini¹, Klodian Gjeloši¹, Emanuele Pinotti¹, Roberta Ferrara¹, Teresa Salvatore², Giovanna Cuomo². ¹University of Campania Luigi Vanvitelli, Department of Medical and Surgical Sciences, Caserta, Italy; ²University of Campania Luigi Vanvitelli, Medicina di precisione, Caserta, Italy

Background: Systemic Sclerosis (SSc) is a multisystem connective disease characterized by a microvascular damage, which leads to systemic fibrosis, immune dysregulation and progressive involvement of internal organs [1].

According to the classification of the morphological aspects, into the scleroderma pattern proposed by Cutolo et al. are described the early, active and late patterns.

Objectives: The aim of our study is thus to report a correlation between specific nailfold videocapillaroscopy pattern and internal organ involvement.

Methods: All enrolled patients were diagnosed for SSc, according to the American College of Rheumatology criteria and underwent an echocardiographic examination and a nailfold videocapillaroscopy.

Myocardial function parameters considered were: global contractility (computed with the Simpson method), linear contractility (computed through the MAPSE) [2], diastolic dysfunction (through the analysis of the transmitral flow) [3]; whilst those of lung damage were: PAPs and the evaluation of the right ventricle contractility through the TAPSE [4].

Statistics were performed with SPSS 20 software, by using the Mann Whitney U Test and the Fisher Test.

Results: We enrolled 27 patients, of which 16 showing "active pattern" and 11 "early pattern", compared to a group of 21 healthy controls.

Of the 11 patients belonging to the "early" group, 1 resulted affected by diastolic dysfunction, whilst 3 had pulmonary hypertension, defined by PAPs ≥40 mmHg [4] (early vs controls; p=0.03). In the 16 patients of the "active" group, instead, 5 were found to have a diastolic dysfunction (active vs controls; p=0.01) and 6 pulmonary hypertension (active vs controls; p=0.003). In the group with "active" pattern we also observed a reduction in TAPSE compared to the control group (2.0 ± 0.2 vs 2.2 ± 0.2; p=0.025) and compared to the group with early pattern (2.0 ± 0.2 vs 2.2 ± 0.3; p=0.07).

No presence of modifications in the global contractility emerged; however, we observed a progressive reduction of the MAPSE (controls 1.76 ± 0.08; early 1.57 ± 0.04; active 1.49 ± 0.12), which resulted statistically significant among the different comparisons (controls vs early p=0.001; controls vs active p=0.0001; early vs active p=0.04).

Conclusion: The analyses showed a strict correlation between the severity of the microvascular alterations, reported by nailfold videocapillaroscopy, and the severity of the cardiopulmonary damage, expressed by an increase in the percentage of pulmonary hypertension, diastolic dysfunction and a progressive reduction of MAPSE and TAPSE.

Abstract AB1155 Table 1. early vs controls

	EARLY	CONTROLS	P
PAPs	32,3 ± 5,4	22,6 ± 6,7	0,0001
TAPSE	2,2 ± 0,3	2,2 ± 0,2	NS
MAPSE	1,57 ± 0,04	1,76 ± 0,08	0,0001
EF	65 ± 4	64 ± 2,7	NS
E/A	1,34 ± 0,2	1,38 ± 0,19	NS
DECT	148 ± 23	163 ± 27	NS
Diastolic dysfunction	1(11)	0(21)	0,3
Pulmonary hypertension	3(11)	0(21)	0,03

Abstract AB1155 Table 2. active vs controls

	ACTIVE	CONTROLS	P
PAPs	34 ± 7,8	22,6 ± 6,7	0,0001
TAPSE	2,0 ± 0,2	2,2 ± 0,2	0,025
MAPSE	1,49 ± 0,12	1,76 ± 0,08	0,0001
EF	65 ± 4	64 ± 2,7	NS
E/A	1,34 ± 0,4	1,38 ± 0,19	NS
DECT	157 ± 24	163 ± 27	NS
Diastolic dysfunction	5(16)	0(21)	0,01
Pulmonary hypertension	6(16)	0(21)	0,003

REFERENCES

- [1] LeRoy EC. Systemic sclerosis. A vascular perspective. Rheum Dis Clin North Am.
- [2] Ibadete Bytci, Left atrial change in early stages of heart failure with preserved ejection fraction. Echocardiography
- [3] Sherif F. Recommendations for the Evaluation of Left Ventricular Diastolic Function by Echocardiography. Journal of the American Society of Echocardiography
- [4] Luke S. Howard, Echocardiographic assessment of pulmonary hypertension: standard operating procedure. European Respiratory Review

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.4613

AB1156

DEFINITION OF TWO NEW ULTRASOUND ENTHESEOPHYTES SCORES: APPLICATION IN A CONSECUTIVE SERIES OF IBD PATIENTS

Pierluigi Macchioni¹, Federica Martinis², Giorgia Citriniti³, Nicolò Girolimetto⁴, Carlo Salvarani¹. ¹Arcispedale S Maria Nuova, IRCCS, Reggio Emilia, Italy; ²Policlinico GB Rossi, University of Verona, Verona, Italy; ³University of Modena and Reggio Emilia, Modena, Italy; ⁴Rheumatology Unit, Department of Clinical Medicine and Surgery, University Federico II, Napoli, Italy

Background: Recent studies have developed criteria for US definition of enthesal abnormalities [1] however no actual scores are available to